VERMONT

Department of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, VT 05495
www.dvha.vermont.gov

Telephone: 802-879-5903

Fax: 802-879-5963

VERMONT MEDICAID OUT-OF-STATE PREADMISSION REQUEST FORM

(For Admissions to Out-of-State Hospitals Excluding Border Hospitals)

Elective Out-of-State (OOS) Inpatient Admissions – Elective inpatient admissions to all OOS hospitals require a prior authorization from the DVHA Clinical Unit. The admitting facility must fax a completed copy of this form and clinical documentation including an explanation of why the proposed care cannot be provided in the State of Vermont, to (802) 879-5963.

The prior authorization must be requested as early as possible and no less than 3 business days prior to the planned admission.

Date of Request: _____

Beneficiary / Admission Information

Patient Name: (last) _____ (first) _____

Medicaid ID Number: _____ Date of birth: _____ Gender: M F (please circle)

Date of Admission: _____ Date of Procedure: _____

Anticipated Discharge Date: _____ Discharge Date: _____

Provider Information

Admitting Provider Name: _____ VT Medicaid Provider #: _____

NPI #: _____ Taxonomy #: _____

Address: _____ Telephone: _____

Contact Person Name: _____ Telephone: _____ Fax: _____

Facility Information

Facility Name: _____ VT Medicaid Provider #: _____

NPI #: _____ Taxonomy #: _____

Address: _____ Telephone: _____

Contact Person Name: _____ Telephone: _____ Fax: _____

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Diagnosis: _____ICD-9 Code: _____ Procedure: _____ CPT Code: _____

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Patient Medicaid ID #: _____

MANDATORY:

Supporting documentation (Dated and Signed) is required from the patient's specialist provider within Vermont, at a listed border facility, or from the Vermont primary care provider if there has been found to be no available specialist within Vermont or at a border facility. The documentation must provide a determination that a level of care is not available to treat his/her patient in a Vermont facility or at a designated Vermont border facility.

Clinical Information: Please justify admission and current status.

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Please explain circumstances surrounding the admission.

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Specific Treatment Plan

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Relevant History

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Additional Information

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Admitting Provider Signature: _____ Date: _____

Note: This patient's medical record may be subject to a DVHA medical record review.